MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10397

200a

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sue Cole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 22, 1948

8. AGE: Years | Months: 4 | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Charles Cole

13. Birthplace: Ky.

MOTHER — 14. Maiden name: Alice Bowie

15. Birthplace: Marlboro, Md.

16. Informant: Mrs. Chas. Cole (Mother)

Address: Marlboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/23/48 (month) (day) (year)

Cemetery or crematory: Church Yard

Location: Marlboro Md.

18. Funeral director: Hewitt & Rogers

Address: Nadoy, Md.

19. Oct. 23 1948 (Date rec'd by registrar) Mary Sweetland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22, 1948 about at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 22 1948 to ..... 19.....

and that I last saw him on Oct. 22, 1948

	DURATION
Immediate cause of death: Sudden death due to	
natural causes, unknown	Minutes
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

Deputy Medical Examiner

23. SIGNATURE: John L. MacKaronagh M.D. M. D. or other

Address: La Plata, Md. Date signed 10-22-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

10398

CERTIFICATE OF DEATH

Reg. Diat. No. 1007

1. PLACE OF DEATH:

County: Charles

City or town: Offaloue Morgantown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [redacted] Several hrs.

Hospital, institution, or street address where death occurred:

Potmac River

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Claude Fullerton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ABT. 1913

8. AGE: Years: 35 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Garret P.a (Town, county, and state)

10. Usual occupation: Police

11. Industry or business

FATHER

12. Name: John Fullerton

13. Birthplace: Garret P.a

MOTHER

14. Maiden name: Vera Sipe

15. Birthplace: Harrisdale P.a

16. Informant: John Fullerton

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 8 1948 (month) (day) (year)

Cemetery or crematory: Harlem Cemetry

Location: Garret P.a

18. Funeral director: Arthur E. Simmons Jr

Address: 2007 Nicholas Ave SE Washington D.C.

19. Nov 8 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28, 1948, at 3:30-4:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 28, 1948, to ..... 19..... and that I last saw him alive on Nov. 7, 1948

Immediate cause of death	DURATION
Accidental drowning	Minutes
Due to: Boat overturned	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 10-28-48

Where did injury occur? Morgantown (City or town) Charles (County) Md (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury: Boat overturned Injured at work? NO

Deputy Medical Examiner

23. SIGNATURE: John L MacKenzie, M.D. M. D. or other

Address: La Plata Md Date signed 11-7-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10399

CERTIFICATE OF DEATH

Reg. Diat. No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Rural Waldorf,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Geppert

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband ~~or wife~~: Carl Geppert
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 27, 1874
8. AGE: Years: 74 Months: 3 Days: 29 If less than one day: hrs. min.
9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Gustave Thomm
13. Birthplace: Poland
MOTHER 14. Maiden name: unknown
15. Birthplace: "
16. Informant: Carl Geppert
Address: Waldorf, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof 10/30/48 (month) (day) (year)
Cemetery or crematory: Washington Nat.
Location: Suitland, Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf, Md.
19. (Date rec'd by registrar) 10-29 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948, at 4:30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/16 1948 to 10/26 1948
and that I last saw h.e.r alive on 10/25 1948
Immediate cause of death: Myocardial Collapse
Due to: Cardio Vas. Renal
Due to: Hypertension
Due to: Senility

DURATION

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Wabon M.D.
M. D. or other
Address Waldorf, Md. Date signed 10/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 159

10400

Reg. Dist. No. 101

1. PLACE OF DEATH:

County Charles

City or town Riverside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~Baby~~ Henson, DORTHY ANN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cd	

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) October 23 1948

8. AGE: Years | Months | Days | If less than one day ... hrs. 2 min.

9. Birthplace Riverside Charles Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Walter Carroll

FATHER 13. Birthplace Riverside, Md.

MOTHER 14. Maiden name Katie Henson

MOTHER 15. Birthplace Riverside, Md.

16. Informant Katie Henson

Address Grayton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26 1948 (month) (day) (year)

Cemetery or crematory Oak Grove

Location W. Riverside

18. Funeral director Walter Carroll.

Address Riverside Md.

19. Oct. 24 1948 (Date rec'd by registrar) Mary Smithland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Prematurity	
No Physician in attendance	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bickwell M.D. M. D. or other

Address Hagerstown Md Date signed Oct 24 48

M

C

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T

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157d

10401

CERTIFICATE OF DEATH

Reg. Dist. No. 2[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: La Plata – En route

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En route

Hospital, institution, or street address where death occurred:

D.O.A. Physicians Memorial Hospital

How long in hospital or institution? D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Joseph Harold Hubbard, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 9, 1948

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
0	7	2		

9. Birthplace: Leonardtown, St. Mary's, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: —

FATHER

12. Name: Joseph Harold Hubbard

13. Birthplace: Indiana

MOTHER

14. Maiden name: Mary Elizabeth Bowles

15. Birthplace: Palmer, Md.

16. Informant: Mrs. Mary E. Hubbard

Address: Waldorf, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13, 1948 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: Brightwood Ind.

18. Funeral director: W. F. Mattingly Sons

Address: Leonardtown, Md.

19. 10/12/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1948 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 11, 1948, to [illegible] 19[illegible] and that I last saw him alive on Oct. 11, 1948.

Immediate cause of death	DURATION
Undetermined accurately — presumably, brain abscess	1 wk.
Due to: Unknown, presumably, congenital	
Due to: brain anomaly	7 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James L. MacKaronagh, M.D. Deputy Medical Examiner

M. D. or other

Address: La Plata, Md. Date signed: 10-11-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10402

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Pisco

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hours.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Pisco

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Paul Jenkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct 27 1948

8. AGE: Years | Months | Days | If less than one day: 16 hrs. ... min.

9. Birthplace: Pisco, Charles Co. Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Johnnie Jenkins

FATHER — 13. Birthplace: Accomac Co. Va.

MOTHER — 14. Maiden name: Ruby Wheeler

MOTHER — 15. Birthplace: Charles Co. Md.

16. Informant: Johnnie Jenkins

Address: Pisco Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29 48 (month) (day) (year)

Cemetery or crematory

Location: Home - Pisco

18. Funeral director: J. Jenkins

Address: Pisco Md.

19. Oct. 28 1948 (Date rec'd by registrar) Mary Southerland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1948, at 1 10 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Oct 27 1948

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Geo. C. Birkwell M.D. M. D. or other

Address: Marbury Md. Date signed Oct 28 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

10403

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: Bryans Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Bryans Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Layton Morris

3.(b) Social Security Number 579184360.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertie Morris
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): April 8, 1907

8. AGE: Years	Months	Days	If less than one day
41	6	14	hrs. min.

9. Birthplace: Deerfield Va.
(Town, county, and state)
10. Usual occupation: Automobile Mechanic
11. Industry or business: Truck Transfer Co

FATHER
12. Name: William Thomas Morris
13. Birthplace: Rockingham County Va

MOTHER
14. Maiden name: Idd M. Rowe
15. Birthplace: Bath County, Va.

18. Informant: Bertie Morris
Address: Bryans Road. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 25, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Washington D. C.

18. Funeral director: Walsh Funeral Home.
Address: 741 11th St. S.E Wash. D. C.

19. Oct. 22 1948 Odey Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1948 at 4P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 18 1948 to Oct. 22 1948 and that I last saw h(im) alive on October 28 1948

Immediate cause of death	DURATION
Coronary Embolism	1 day
Due to: Acute Myocarditis	4 days.
Due to:	
Other conditions: Chronic Nephritis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Franklin Swann M. D.
M. D. or other
Address: Indian Head, Md. Date signed: 10-22-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55 b

10404

Reg. Diat. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1

Hospital, institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Edward W. Robertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 2, 1857

8. AGE: Years: 91 | Months: 7, | Days: 7 | If less than one day: ... hrs. ... min.

9. Birthplace: Charles Co. Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER — 12. Name: John Robertson

13. Birthplace: Chas. Co. Md.

MOTHER — 14. Maiden name: Roberta Wallis

15. Birthplace: Montgomery Co. Md.

16. Informant: Wallace Barnes

Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/12/48 (month) (day) (year)

Cemetery or crematory: Mt. Rest

Location: La Plata, Md

18. Funeral director: Hewitt & Ryon

Address: Waldorf, Md.

19. 10-12 1948 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1948 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1936 to Oct. 9, 1948 and that I last saw him alive on October 8, 1948

Immediate cause of death	DURATION
Shock and prolonged vomiting from fracture rt. hip.	2 days
Due to: Osteosarcoma rt. hip	1-2 yrs.
Due to:	
Other conditions: Coronary artery disease	3 yrs.
Rheumatoid arthritis	10-12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: Stumbled but did not fall Injured at work?

23. SIGNATURE: James L. MacKaye M.D. M. D. or other

Address: La Plata, Md. Date signed: 10-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

10405

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: LaPlata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Newport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Daniel H. Ryce

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude Wank
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1870

8. AGE: Years: 78 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: St. Marys Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: James Ryce
13. Birthplace: St. Marys

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Wilson W. Ryce
Address: Newport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-21-48 (month) (day) (year)
Cemetery or crematory: Christ Church
Location: Waldorf Md.

18. Funeral director: Hurst & Ryon
Address: Waldorf

19. 10-21 1948 (Date rec'd by registrar) Julia H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1948 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1948 to Oct 18 1948 and that I last saw h[illegible] alive on Oct 18 1948

	DURATION
Immediate cause of death: Shock	10-15-48
Due to: Fractured Hip	10-14-48
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10/15/48
Where did injury occur? Newport (City or town) (County) Md. (State)
Injured at home, farm, industrial, public place (where?) Home
Means of injury: Certified - Fell, getting out of bed. Injured at work?

23. SIGNATURE: L. Hedelen M.D.
M. D. or other
Address: LaPlata Md. Date signed 10-18-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10406

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 103

1. PLACE OF DEATH:
County: Charles
City or town: Faulkner
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Faulkner
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harold Serviss Swann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife: Elizabeth Swann
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1879

8. AGE: Years	Months	Days	If less than one day
69	3	25	hrs. min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Oil Distributor
11. Industry or business: Retired
FATHER 12. Name: Andrew J. Swann
13. Birthplace: Connecticut
MOTHER 14. Maiden name: Ann Serviss
15. Birthplace: New Jersey
16. Informant: Mrs Anna Wilds
Address: Faulkner, Md.
17. Burial, cremation, or removal. Which?: Burial Date thereof: 10/9/48 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Newport, Md.
18. Funeral director: Hiett & Ryon
Address: Waldorf, Md.
19. 10-9-48 19 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-6 1948, at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-2 1941, to 10-6 1948 and that I last saw h.. alive on 10-6 1948

Immediate cause of death	DURATION
Coronary Occlusion	10-6-48
Due to: Arterio Sclerotic Heart	
Due to: Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: LaPlata, Md. Date signed: 10-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10407

CERTIFICATE OF DEATH

Reg. Dist. No. 10C

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emilia Voglino

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Frank A.
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov. 1st, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	30	...hrs. ...min.

8. Birthplace: Italy
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Alphonso Mignone
13. Birthplace: Italy
MOTHER 14. Maiden name: Frances Carino
15. Birthplace: Italy
16. Informant: Frank Voglino
Address: Waldorf, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3-48 (month) (day) (year)
Cemetery or crematory: St. Peter's
Location: Waldorf, Md.
18. Funeral director: Huntt & Ryon
Address: Waldorf, Md
19. Nov 3 19 48 M L Mowell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 | 31 19 48, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 | 26 19 48 to 10 | 31 19 48 and that I last saw h.. ev.. alive on 10 | 30 19 48

Immediate cause of death: Cerebral Apoplexy — DURATION: 2 weeks
Due to: Cardio-Vas. Renal Disease — DURATION: 4 years
Due to: Hypertension
Other conditions: Senility
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Geo. A. Lowber, M.D.
M. D. or other
Address: Waldorf, Md. Date signed: 11/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M